Substance Abuse in Brief Fact Sheet

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Identifying and Helping Patients With Co-Occurring Substance Use and Mental Disorders: A Guide for Primary Care Providers

It is estimated that approximately 4.6 million American adults have both substance use disorders (SUDs) and mental disorders (MDs).[1] Other terms for these co-occurring disorders (CODs) are dual diagnosis and comorbidity. Early recognition and treatment of these CODs are essential to improving treatment outcomes and quality of life for these patients.[2] This publication will help primary care providers identify patients with CODs and provide appropriate treatment for these patients.

Identifying Patients With COD

Primary care providers, such as physicians, physician's assistants, and nurse practitioners, are in an excellent position to help their patients with both SUDs and MDs. These disorders may exacerbate or be related to other health problems, such as headaches, cardiovascular disease, high blood pressure, diabetes, digestive disorders, and cirrhosis,[3,4] so patients with CODs may often seek medical care from primary care providers. Hence, primary care providers may have established a relationship with their patients conducive to discussing SUDs and MDs.

Barriers to identifying and treating co-occurring disorders in the primary care setting include the following:

- **Low rates of screening**,[5, 6] **correct diagnosis**,[7, 8] and **appropriate referral.**[5]
- **Patient denial.**[9] Patients may not realize they have a problem. Approximately one-third of patients do not disclose self-perceived SUDs or MDs to their primary care provider.[10]
- **Patient reluctance to talk to the provider.** The stigma of CODs still exists, and many patients are afraid to admit they have a problem.[3]
- **Provider attitudes.**[7, 11] Providers may fail to make the possible link between physical symptoms and SUDs and/or MDs when assessing a physical problem. Providers' preconceptions and attitudes can also hinder identification of such disorders.
- **Inadequate training.** Many providers receive inadequate education on CODs and their effects on other medical conditions.[3]
- **Time constraints due to short appointment times.**[9]

Some barriers can be overcome by incorporating three components into the primary care practice: (1) obtaining an annual patient history on substance use and mental health issues, (2) being aware of warning signs that may be related to an SUD or MD, and (3) screening routinely for CODs.

Patient History

All patients should complete an annual health history, including questions about personal and family history of substance use and mental health issues.[12] Questions about victimization, trauma, personal, and social issues (e.g., unemployment, legal problems, homelessness, financial or marital difficulties) should be included because these can be related to SUDs and MDs.[11, 12, 13] Primary care providers should ask questions about substance use and mental health symptoms, preferably in the context of other lifestyle questions so that these potentially sensitive topics seem less threatening to patients.[14] An open, empathetic, and nonjudgmental attitude is essential to encouraging patients to talk about their symptoms.[11]

COD Red Flags[11, 13, 15, 16]

- Nasal irritation (SUD only)
- Unexplained bruises (SUD only)
- Enlarged liver or spleen, abnormal liver function, hepatitis, or cirrhosis in later stages (SUD only)
- Withdrawal symptoms (SUD only)
- Headaches
- Chest pain or cardiac arrhythmia
- Gastrointestinal symptoms
- Hypertension
- Sexual dysfunction
- Fatigue
- Apathy or flat affect
- Social withdrawal
- Changes in concentration, mood, activity level, sleeping, appetite, or weight
- Feeling of worthlessness or inappropriate guilt
- Fear, worry, or repetitive, intrusive thoughts or actions
- Problems with cognition or impulse control
- History of physical or mental trauma

*These symptoms appear in combination and may indicate other problems as well as COD.

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Warning Signs

Most patients will not visit a primary care setting with obvious, immediate signs of an MD, such as delirium, confusion, or disorientation, or an SUD, such as odor of alcohol on the breath or marijuana on clothing, dilated pupils, slurred speech, or needle marks. However, warning signs—"red flags"—for SUDs and MDs can manifest in subtle physical or behavioral symptoms (see sidebar on front page). For example, many patients with CODs present with physical complaints, such as insomnia, fatigue, chest pain, cardiac arrhythmia, headaches, or impotence. When other physical or psychological causes cannot be found, an SUD, an MD, or a COD should be considered. These disorders should also be considered when a patient with a chronic disease, such as chronic pain, diabetes, heart disease, gastrointestinal disorders, or hypertension, fails to respond to treatment.[15]

Although primary care providers should not immediately identify mental disorder symptoms as being caused by an SUD, it is important to note that many mental disorders, including mood, anxiety, sleep, and sexual disorders, can be induced by substance use. The only difference between substance-induced mental disorders and independent mental disorders is that all or most of the symptoms of a substance-induced disorder are a direct result of substance use, abuse, or withdrawal rather than mental illness. When substance-induced disorders are suspected, primary care providers should continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance abuse over time.[11]

Triple Threat: SUDs, MDs, and HIV/AIDS

Healthcare providers should be aware that some people with CODs are infected with HIV.[24] CODs may interfere with effective HIV care because of many factors, including poor adherence to antiretroviral therapy.[24, 25] In addition, the presence of HIV infection may result in more severe co-occurring symptoms. Patients with HIV should be screened regularly for CODs. The Health Resources and Services Administration's report, *A Guide to Primary Care of People With HIV/AIDS*, provides valuable information on managing co-occurring disorders in patients with HIV/AIDS.[13]

Screening

Standardized screening instruments help identify patients with potential CODs. Ideally, every patient should be screened. At the very least, any patient presenting with signs or symptoms of either a mental or a substance use problem should be evaluated for both disorders.[16] Although many SUD and MD screening tools can be used in a primary care setting (e.g., the CAGE-AID,[14] the Mental Health Screening Form-III,[11] the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire™[20]), busy healthcare providers may find administering these tools time consuming.

Recent research has shown that one- or two-item screeners are effective in identifying those at risk for an SUD or MD (see exhibit 1).[17, 18, 19, 20] Because the screener questions can be answered in seconds, they can be asked during routine visits. Computerized screeners, such as the Drug Abuse Problem Assessment for Primary Care[21, 22] (DAPA-PC), are also effective when time is limited. The DAPA-PC is an Internet-based, self-administered screener for alcohol and drug use that scores patient responses, generates a patient profile for the healthcare provider, and offers motivational

Exhibit 1. Brief Screening Tests

Problem	Questions	Possible Responses	Positive Screen
Alcohol[18]	When was the last time you had more than four (for women)/five (for men) drinks in 1 day?	1) never 2) in the past 3 months 3) over 3 months ago	in the past 3 months
Alcohol or Drugs[17]	In the last year: 1) Have you ever drunk alcohol or used drugs more than you meant to? 2) Have you felt you wanted or needed to cut down on your drinking or drug use?	yes or no	yes to either question
Depression[20]	During the past 2 weeks: 1) Have you often been bothered by feeling down, depressed, or hopeless? 2) Have you often been bothered by little interest or pleasure in doing things?	yes or no	yes to either question

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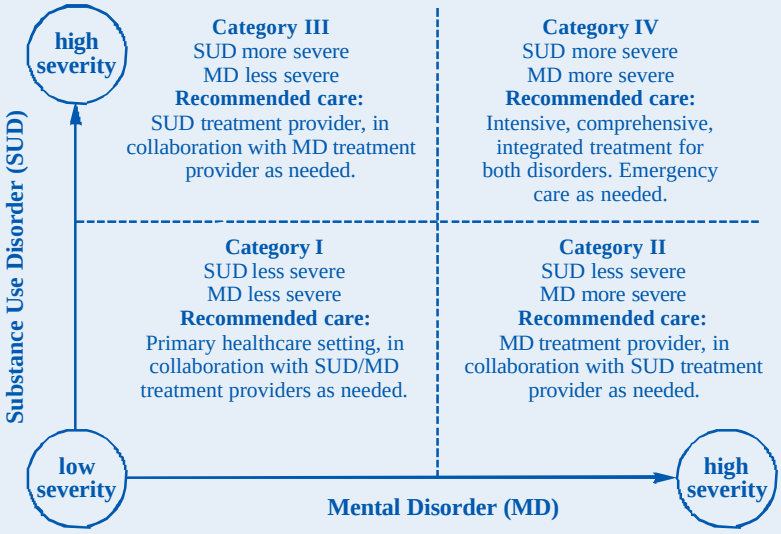
messages and advice to the patient. A similar screener for identifying CODs has recently been developed.[23]

Treatment for Patients With COD

All patients who screen positive for a COD need a thorough assessment. The Quadrants of Care Model, a framework that classifies persons with CODs into four basic groups based on symptoms and relative symptom severity, helps determine appropriate patient care based on the type and severity of the patient's symptoms (see exhibit 2).[11] Patients with severe CODs or those whose symptoms worsen should be referred for further assessment and/or treatment by a specialist, but many patients may delay or refuse seeing a substance abuse treatment or mental health provider.[2] In addition, the gap between the availability of treatment slots and the brevity of formal treatment may result in referred patients returning to the primary care provider for COD treatment.[26] Some patients may need to be screened for suicidality because persons with CODs are at increased risk for committing suicide.[11]

Exhibit 2. Quadrants of Care Model



An effective way to address mild to moderate CODs in the primary care setting is through a brief intervention. Brief interventions—short, patient-centered interventions aimed at modifying behavior—have been shown to be effective in reducing alcohol[27] and drug use[28] as well as anxiety and depression[29] when used in the primary care setting. Brief interventions typically are provided over one to five visits and consist of the following:[19, 30, 31]

1. Providing simple, concise **feedback** on patients' risk for COD based on their histories, physical and behavioral warning signs, screening test results, and information on how these disorders affect them;
2. Offering clear oral and written **advice**, including recommendations on safe alcohol consumption limits, the negative effects of alcohol and drug use, and behavior modification; and
3. Establishing a mutually consented **plan of action** that addresses SUDs and MDs as appropriate and includes specific goals for behavior change, prescription of behavioral or pharmaceutical treatments, referrals for further assessment and treatment when appropriate, and followup plans, either in person or via the telephone

The National Institute on Alcohol Abuse and Alcoholism's publication *Helping Patients Who Drink Too Much: A Clinician's Guide* and the complementary *A Pocket Guide for Alcohol Screening and Brief Intervention* provide valuable information about conducting brief interventions in the primary care setting.

Ways To Help Patients With CODs

- Provide feedback and advice in a clear, concise, nonjudgmental, and supportive manner. Empathy is particularly important because CODs are still associated with shame and guilt by many persons.[30]
- Talk about these disorders in a matter-of-fact way—as treatable conditions—to put the patient at ease and encourage cooperation.[30, 32]
- Become familiar with and refer patients to 12-Step or mutual-help organizations such as Alcoholics Anonymous (www.aa.org), Double Trouble in Recovery (www.doubletroubleinrecovery.org), and Narcotics Anonymous (www.na.org).
- Develop relationships with local substance abuse and mental health treatment providers, including those providing integrated treatment.
- Stay current on COD research and practices by visiting the Web sites of the Substance Abuse and Mental Health Services Administration's Co-Occurring Center for Excellence (coce.samhsa.gov), the National Mental Health Association (www.nmha.org), and the National Alliance on Mental Illness (www.nami.org), as well as by participating in COD-specific training or continuing education.

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Resources

Publications

- TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (www.samhsa.gov)
- *Helping Patients Who Drink Too Much: A Clinician's Guide* (pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf)
- KAP Keys and Quick Guide for Clinicians Based on TIP 24: *A Guide to Substance Abuse Services for Primary Care Clinicians*, NCADI #s KAPT24 and QGCT24
- KAP Keys and Quick Guide for Clinicians Based on TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse*, NCADI #s KAPT34 and QGCT34
- KAP Keys and Quick Guide for Clinicians Based on TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, NCADI #s KAPT42 and QGCT42
- *HIV/AIDS: Is Your Client at Risk?* NCADI # MS965
- *Alcohol Use Among Older Adults: Pocket Screening Instruments for Health Care and Social Service Providers*, NCADI # PHD883
- *Special Feature Kit: Overcoming Addiction and Mental Disorders*, NCADI # AMDKIT
- *Building Bridges—Co-Occurring Mental Illness and Addiction: Consumers and Service Providers, Policymakers, and Researchers in Dialogue* (www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3892)
- *Improving the Quality of Health Care for Mental and Substance Use Conditions* (fermat.nap.edu/catalog/11470.html)
- *Co-Occurring Disorders: Integrated Dual-Disorders Treatment* (www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring)

See ordering information for National Clearinghouse for Alcohol and Drug Information (NCADI) publications on the back cover.

Web Sites

- Substance Abuse Treatment Facility Locator (www.findtreatment.samhsa.gov; 1-800-662-HELP)
- Mental Health Services Locator (www.mentalhealth.samhsa.gov/databases)
- Co-Occurring Center for Excellence (COCE) (www.coce.samhsa.gov)
- National Mental Health Information Center (NMHIC) (www.mentalhealth.samhsa.gov)
- National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov)
- Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

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